National and State Performance Measure Notes

PM1. The percent of State SSDI beneficiaries less than 16 year sold receiving rehabilitative services from the State Children with Special Health Care Needs Program.
The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and Washington State SSI applicant data. The available denominator for children receiving SSI included children through age 17. The number is adjusted by subtracting the estimated number of children age 16 and 17 receiving SSI from the State total. The estimate is derived using the average proportion of children 16 and 17, nationally. The numerator is obtained from the CHIF database. No adjustment is made to the numerator because virtually all children served are under age 16. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

PM2. The degree to which the State Children with Special Health Care Needs Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.
The source of these data is the Washington State CSHCN program. The Washington CSHCN Program covers all of the specialty and subspecialty services listed as the payor of last resort with the exception of home health care. Medicaid covers home health care services for Medicaid eligible children. We do not anticipate any change in this policy as reflected in the performance objectives.

PM3. The percent of Children with Special Health Care Needs in the State who have a "medical/health home."
This estimate for CSHCN with a medical home was derived from results of a Consumer Assessment of Health Plan Survey (CAHPS) conducted by Washington State Medical Assistance Administration (MAA) in spring 2000. The survey included a Living with Illness Module developed by the Foundation for Accountability (FACCT) in order to identify CSHCN, and incorporated questions specifically designed to measure quality of health plan services for CSHCN. A composite measure of medical home was developed by FACCT based on the American Academy of Pediatrics definition of Medical home, and incorporated the following components: personal health care provider, with scores for the following elements of care: accessible, comprehensive, culturally sensitive, coordinated, and family centered care. The survey sample was a stratified random sample of children 0-12 yrs enrolled in Medicaid managed care for at least 6 months. The sample was stratified by the 9 managed care plans serving Medicaid clients at the time. A response rate of approximately 50% was achieved. Overall, about 34% of the state's children are covered by Medicaid, the majority in managed care. It is not known whether the survey sample is representative of the entire state's CSHCN population, nor how CSHCN covered by Medicaid compare to those not covered by Medicaid.

PM4. The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinapathies. Population Based Service
These data come from the Washington State DOH Office of Newborn Screening database (updated monthly). The numerator is the number of liveborn infants born in Washington that were reported as screened by the Office of Newborn Screening (infants born on U.S. Military Installations are excluded). The denominator is the number of live births occurring in Washington. Washington does not screen for galactosemia. The state currently screens for adrenal hyperplasia, PKU, hypothyroidism, and hemoglobinopathies.

PM5. The percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. Population Based Service

The source of the data is the National Immunization Survey, 1999, Centers for Disease Control and Prevention (CDC). The data were obtained at the following site: www.cdc.gov/nip/coverage/jan-dec99_toc.htm. Reporting for this measure has changed this year. In previous years, we measured the percent of children through age 2 who have completed immunizations of Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis and Haemophilus Influenza. This year immunizations for Hepatitis B were also included. The 95% Confidence Interval for this measure is $\pm$ 4.4. This estimate is based on the provider-verified responses from children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers.

PM6. The rate of births (per 1,000) for teenagers ages 15-17 years. Population Based Service

The source of these data is the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October). The numerator is defined as the number of live births to women ages 15-17. The denominator is defined as the estimated number of 15-17 year old women in Washington on April 1, 1999 reported by the Department of Social and Health Services, Research and Data Analysis, in the *Washington State Adjusted Population Estimates*, based on estimates by Claritas, Inc, and Office of Financial Management, July 1999.

PM7. The percent of third grade children who have received protective sealant on at least one permanent molar tooth. Population Based Service

The percent of third grade children who have received protective sealants on at least one permanent molar tooth is 55.5% (95% Confidence Interval is 52.7-58.3). These data were obtained from the Smile Survey 2000. For this survey, an electronic list of all public elementary schools in Washington was obtained from the Office of the Superintendent of Public Instruction. Fifty-five schools with at least 25 children in second and/or third grade were randomly selected for participation. Seven of the schools refused to participate resulting in 48 schools with a total enrollment of 6,814 children in second and third grade. Of the total 2,699 children who participated, 1,217 were in third grade. Schools who participated were more likely to have a low-income student body, and students who participated were also more likely to be low income. The children taking part in this survey are not representative of the state as a whole, since both minority children and low-income children were over-sampled. Since income has been shown to be related to sealant use, this estimate may underestimate the true percentage of third graders with at least one sealant on a permanent molar tooth. The denominator is the estimated number of 8 year-old children in Washington on April 1, 2000 reported by the Department of Social and Health Services, Research and Data Analysis, in the Washington State Adjusted Population Estimates, based on estimates by Claritas, Inc, and Office of Financial Management, July 1999. No new data for this measure was available in 1999. The 1998 indicator for this measure has been used for 1999, though the 1999 numerator and denominator have been changed to reflect 1999 population estimates.

PM8. The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children. Population Based Service

The source of the data is the Washington State Center for Health Statistics Death Certificate Files (updated annually between September and October). The numerator is defined as the number of Motor Vehicle Crash (MVC) deaths (underlying cause of death are ICD 10 codes: V02-V04,V09.0,V09.2,V12-V14,V19.0-V19.2,V19.4-V19.6,V20-V79,V80.3-V80.5,V81.0-

V81.1,V82.0-V82.1,V83-V86,V87.0-V87.8,V88.0-V88.8,V89.0,V89.2) occurring to children aged 1-14 years. The denominator is defined as the estimated number of children 1-14 years in Washington on April 1, 1999 reported by the Department of Social and Health Services, Research and Data Analysis, in the *Washington State Adjusted Population Estimates*, based on estimates by Claritas, Inc, and Office of Financial Management, July 1999. The cause-specific mortality rate for this indicator for 1999 has been calculated using ICD-10 codes, while the previous years rates were calculated using ICD-9 codes. Therefore, in order to make comparisons over time, for all years previous to 1999, the cause-specific rates must be multiplied by the comparability ratio of 0.85 (based on preliminary estimates from the National Center for Health Statistics: National Vital Statistics Report; Vol 49: No. 2). We used this method to draw the inferences reported in the review of performance measures.

PM9. The percentage of mothers who breastfeed their infants at hospital discharge. Population Based Service

The source of these data is the 1999 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS). The numerator is defined as the estimated number of women who reported breastfeeding at any time. The denominator is defined as the total number of women giving birth. PRAMS surveys were sent to 1744 women in 1999. The data are based on the survey responses of the 1263 women who participated (72% response rate).

PM10. The percentage of newborns who have been screened for hearing impairment before hospital discharge. Population Based Service

These data were collected by a telephone survey of hospitals that conduct neonatal hearing screening. The number of hospitals providing newborn hearing screening increased in 2000 from 17 to 21, with 13 hospitals screening all newborns before hospital discharge. Neonatal hearing screening is conducted at 21 facilities in Washington, which have neonatal intensive care units or high-risk nurseries. This survey is currently administered in January of each year, but may be subject to change in the future. This figure also includes infants who were screened at Children's Hospital and Medical Center, which is not a birthing hospital but screens all inpatient and outpatient infants less than 3 months of age. The numerator is defined as the total number of infants screened (as described above). The denominator is defined as the estimated number of resident live births in 2000 as reported by WA State Vital Statistics. Currently there is no way to determine if only resident infants are included in the numerator, nor is there any way to account for resident infants who may have been born and/or screened at out-of-state hospitals.

PM11. The percent of Children with Special Health Care Needs in the State CSHCN program with a source of insurance for primary and specialty care. Infrastructure Building

The source of these data is the CSHCN Child Health Intake Form (CHIF) database that tracks the children served by the CSHCN programs throughout the state. The numerator is the number of children served by the CSHCN program who reported any insurance. The denominator is the number of children served by the CSHCN program. These children are a small proportion (2-3%) of the estimated number of CSHCN in the state**.**

PM12. The percent of children without health insurance. Infrastructure Building

The source of these data is the 2000 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 19. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data. No new data for this measure was available in 1999. The 1998 indicator for this

measure has been used for 1999, though the 1999 numerator and denominator have been changed to reflect 1999 population estimates.

PM13. The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. Infrastructure Building

The source of these data is the Washington State Department of Social and Health Services and Office of Financial Management. The numerator represents the unduplicated count of Medicaid fee-for-service (FFS) and Healthy Options encounters in 1999, for children under age 19 and at or below the 200% FPL. The denominator represents the estimated number of children under age 19 at or below the 200% FPL for 1999 based on data from the 2000 OFM State Population Survey. The data in the denominator from the State Population Survey may not include children whose family income was below 200% of the FPL for a portion of 1999, since the survey measures total yearly income. It is unclear how this affects the final percentage of children who received a service paid for by Medicaid.

PM14. The degree to which the State assures family participation in program and policy activities in the State CSHCN program. Infrastructure Building

The source of these data is the Washington State Children with Special Health Care Needs Program. See notes under Form 16 for details.

PM15. The percent of very low birth weight live births. Infrastructure Building

Very low birth weight (VLBW) is defined as any live born infant weighing less than 1500 grams. The numerator is defined as the number of resident VLBW infants in 1999. The denominator is defined as the total number of resident live births in 1999**.** The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). 1.16% of the data are missing for this measure because the weight was not reported.

PM16. The rate (per 100,000) of suicide deaths among youths ages 15-19. Infrastructure Building

The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and X870 for youth ages 15-19. The denominator is the estimated population for ages 15-19 on April 1, 1999. The rate is per 100,000 population. The source for these data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Department of Social and Health Services, Research and Data Analysis, *Washington State Adjusted Population Estimates*, based on estimates by Claritas, Inc, and Office of Financial Management, July 1999. The cause-specific mortality rate for this indicator for 1999 has been calculated using ICD-10 codes, while the previous years rates were calculated using ICD-9 codes. Therefore, in order to make comparisons over time, for all years previous to 1999, the cause-specific rates must be multiplied by the comparability ratio of 0.99 (based on preliminary estimates from the National Center for Health Statistics: National Vital Statistics Report; Vol 49: No. 2). We used this method to draw the inferences reported in the review of performance measures.

PM17. The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. Infrastructure Building

The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state and are delivered at a hospital providing perinatal intensive care (level III). The denominator represents the total number of VLBW resident infants born in-state. The source for

these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October).

PM18. The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. Infrastructure Building
The source of these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data is excluded. In 1999, 9.5% of the data was missing for this measure.

SP1. The percent of pregnancies that are unintended. Negotiated Population Based Service
This numerator for this measure is derived from [the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey *(resident live births + fetal deaths)] + reported resident abortions. The denominator for this measure is the number of resident live births + fetal deaths + reported resident abortions. In PRAMS, to determine pregnancy intention, women are asked how they felt about becoming pregnant. PRAMS surveys were sent to 1744 women in 1999. The data are based on the survey responses of the 1263 women who participated (72% response rate). Birth, Fetal death, and Abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 1999.

SP2. The percent of pregnant women abstaining from smoking. Negotiated Population Based Service
The source of these data is the Washington State Center for Health Statistics Birth Certificate file. The numerator is the number of resident women who reported abstaining from smoking during pregnancy on the birth certificate. The denominator is all resident births in the reporting year. 6.5% of the data were missing in 1999 for this measure and are excluded from the denominator.

SP7. The percent of pregnant women abstaining from alcohol. Negotiated Population Based Service
The source of these data is the 1999 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey, which asks about alcohol consumption in the third trimester. While alcohol consumption at any time during the pregnancy is asked on the Washington State Birth Certificate, the prevalence estimate from PRAMS is thought to be a more reliable estimate. The measure is determined by the proportion of women who indicated they abstained from alcohol consumption in the third trimester. PRAMS surveys were sent to 1744 women in 1999. The data are based on the survey responses of the 1263 women who participated (72% response rate).

SP3. The percent of women who received counseling from their prenatal health care provider on tests for identifying birth defects of genetic disease. Negotiated Population Based Service
The source of these data is the 1999 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about genetic testing or birth defect screening. PRAMS surveys were sent to 1744 women. The data are based on the survey responses of the 1263 women who participated (72% response rate).

SP6. Increase the number of perinatal providers who have received training in identifying and referring victims of domestic violence during pregnancy and postpartum. Negotiated Infrastructure Building

(Revised from SP11 for 2001 report) The source of these data is the Washington State MCH domestic violence program lead. The MCH office has designed a 'train-the-trainer' program utilizing the Perinatal Partnership Against Domestic Violence curriculum. Each trainer reports annually to the MCH domestic violence lead the number of perinatal providers who received training during the past calendar year. There is no denominator for this measure because it is not possible to obtain the total number of providers in the state who deliver prenatal care.

SP12. Produce and distribute at least two reports annually using MCH surveillance data to monitor trend, promote prevention strategies and influence policy. Negotiated Infrastructure Building

The source for these data is the Washington State MCH Assessment Unit. This measure was not met this year due to personnel setbacks. Two reports should be completed within the following year.

SP11. Increase to 100% the number of local health jurisdictions with dedicated staff time providing public health consultation regarding health and safety in child care programs. Negotiated Infrastructure Building

The source of these data is the Washington State MCH Child and Adolescent Health Child Care Coordinator. The measure is defined as the proportion of local health jurisdictions (LHJs) with dedicated staff time providing public health consultation regarding health and safety in childcare programs.

SP14. Develop and implement a standardized charting tool for well-being screenings in collaboration with Medical Assistance Administration, health plans, and others. Negotiated Infrastructure Building

The source of these data is Medical Assistance Administration (MAA) and DOH. MCH Child and Adolescent Health has collaborated with MAA to complete the Workplan by 7/2000 and Implementation by 7/2001. See notes under Form 16 for details.

SP15. To increase to 90% the proportion of parents with young children sent CHILD Profile health promotion materials. (Deleted for 2001) Negotiated Population Based Service

The source of these data is the Washington State CHILD Profile database (9/30/2000). The numerator is the number of children from birth to 3 years whose parents/guardians have been sent CHILD Profile health promotion materials during the federal fiscal year. The denominator is the estimated number of children in the 0-3 year age range provided by the Department of Social and Health Services, Research and Data Analysis, in the *Washington State Adjusted Population Estimates*, based on estimates by Claritas, Inc, and Office of Financial Management, July 1999.

SP4. Establish state and local capacity for determining the prevalence of children with special health care needs. Negotiated Infrastructure Building

The source of the data is the Washington State CSHCN Program.
Establish a sustainable assessment strategies for assessing children with special health care needs at the state and local level:
1. Developed a method for using hospital discharge data for assessment purposes for children with special health care needs
2. Investigated strategies for using the National Health Institute Survey Disability Supplement to determine synthetic estimates of children with special health care needs for Washington State.
3. Explored possible partnership wit CDC and MCHB to help draft questions for the SLAITS survey
4. Evaluated the feasibility and usefulness of incorporating the "QUICCER QUICC" questions into current CAHPS surveys being used by MAA, HCA, private health plans and others.

5. Provided technical assistance and training on above method to local health districts to promote the assessment of children with special health care needs.

If all are completed by 7/1/00 then achievement=25%

Steps 1-4 were completed in 1999.

6. Conducted a feasibility study (including- cost, periodicity, and acceptability) to determine the usefulness of a periodic household survey to assess the prevalence and health issues of children with special health care needs.

7. Piloted a household survey to determine the appropriateness of its use for children with special health care needs in Washington State.

If all are completed by 7/1/01 then achievement=50%

8. Implemented the appropriate prevalence strategy for Washington State.

If completed by 7/7/04 then achievement=75%

9. Evaluated assessment processes and revise as needed to establish a sustainable method for determining prevalence of children with special health care needs.

If completed by 7/7/05 then achievement=100%

SP 8. The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans. Negotiated Infrastructure building.

The source of these data is 1999 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about smoking, alcohol use, illegal drug use, getting tested for HIV status and postpartum birth control plans. PRAMS surveys were sent to 1744 women in 1999. The data are based on the survey responses of the 1263 women who participated (72% response rate).

SP 6. The percent of Pregnant women screened for domestic violence during their prenatal care visits. Negotiated Infrastructure building.

The source of the data is 1999 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about physical abuse by their husbands or partners. PRAMS surveys were sent to 1744 women in 1999. The data are based on the survey responses of the 1263 women who participated (72% response rate).

SP 7. Increase the capacity of MCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services. Negotiated Infrastructure building

The source of the data is the Washington State DOH Mental Health Committee.

Increase the capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services.

Benchmark Targets to Report on Progress on the Performance Measure:

Year one activities = Target 20% (3 of 15 benchmarks)

If all 3 elements below are completed, the score will be 20%. If items are not completed, the score will be reduced proportionately. (Each item completed is worth 6.6%.)

1. Collected currently available data indicating the level of need and degree of access achieved for mental health services by MCH populations (emphasizing publicly funded services).
2. Identified all MCH activities locally and at the state level to promote early identification and intervention services relative to MH for MCH populations.
3. Conducted literature review regarding best practices for early identification and intervention for mental health concerns among children and adolescents.

Year two activities = Target 47% (7 of 15 benchmarks)
If all 4 elements below are completed, the score will be 47%. If items are not completed, the score will be reduced proportionately. (Each item completed is worth 6.75%.)
4. Surveyed other state MCH offices for strategies they use to promote early identification and intervention.
5. Consulted with local and state constituents (including consumers) to identify strategies MCH will promote for enhancing early identification, prevention and intervention in WA.
6. Continued to monitor level of need for mental health services and degree of access achieved using existing databases.
7. Identified need for additional data collection regarding mental health services and opportunities for additional data collection.

Year three activities = Target 67% (10 of 15 benchmarks)
If all 3 elements below are completed, the score will be 67%. If items are not completed, the score will be reduced proportionately. (Each item completed is worth 6.6%.)
8. Solicited additional funding for mental health assessment, as needed.
9. Developed a MH promotion plan for MCH
10. Solicited funding to implement the plan.

Year four activities = Target 80% (12 of 15 benchmarks)
If all 2 elements below are completed, the score will be 80%. If items are not completed, the score will be reduced proportionately. (Each item completed is worth 16.5%.)
11. Began implementation of plan, as resources allow.
12. Collected and analyze information from plan implementation.
Year five activities = Target 100% (15 of 15 benchmarks)
If all 3 elements below are completed, the score will be 100%. If items are not completed, the score will be reduced proportionately. (Each item completed is worth 6.6%.)
13. Continued implementation of MCH MH promotion plan strategies.
14. Continued data collection and evaluate implementation strategies.
15. Presented process development and strategy at state/national conferences.

SP 5. To reduce the prevalence of the grade youth who report smoking one or more cigarettes in the last 30 days. Negotiated Population Based
The percentage of children in the 8th grade that had smoked cigarettes within the past 30 days is 12.5% (95% CI is ±2.3). These data were obtained from the Washington State Survey of Adolescent Health Behaviors 2000, which was conducted jointly by the Department of Social and Health Services, the Office of the Superintendent of Public Instruction, the Department of Community Trade and Economic Development, and the Department of Health tobacco program. The survey was administered during class time to public school students in grades 6, 8, 10 and 12. The sample was stratified by geographic region and school size, and within these cells, where possible, a school was selected from each of three community types: urban, suburban, and rural. All students in selected schools were invited to participate. The survey asked a variety of questions about alcohol, tobacco, and drug use and risk and protective factors. Data were analyzed using Software for the Statistical Analysis of Correlated Data (SUDAAN) because of the complex sampling design (clustered by schools). Of the 17,870 students who completed the survey, 4,980 were in the 8th grade. The numerator represents the estimated number of 8th grade children that had smoked cigarettes within the past 30 days. The denominator represents the number of children enrolled in the 8th grade public schools in 2000, as reported in the 2000 Juvenile Justine Report, Office of Juvenile Justice.

SP 9. Develop and implement a set of measurable indicators and a strategic plan to improve food security in the Washington MCH population, that is, absence of skipped meals or hunger due to lack of food. Negotiated Infrastructure building

The source of the data is the DOH Nutrition Team.

Develop and implement a set of measurable indicators and a strategic plan to improve nutrition status among the MCH population.

Data Issues

Families with children, especially those having low income, are more vulnerable to the experience of difficulties with adequate food supplies or hunger. A 1995 Census Bureau Current Population Survey indicated that up to 40 percent of poor families with children in the U.S. are at risk of inadequate food supplies or experiencing hunger due to lack of money to provide food for family. 1995-1999 Census Bureau Current Population Survey reports ranked Washington households as above national average in Food Insecurity. Using that Census survey for the years 1996-98 the USDA ranked Washington as 8th among Food Insecurity states. The Urban Institute reported in 1996-97 Washington ranked 6th out of 13 states having families with children reporting one or more food related problems. Among those families with children having incomes under 200% of the Federal Poverty Level, 54% had some worry or difficulty affording food, compared to 17 % in families with incomes over 200% of the FPL.

Benchmark Targets to Report on Progress on the Nutrition Performance Measure:

Completion of 15 sequential steps to develop and implement a set of measurable indicators and a strategic plan for improving Food Security for MCH population. Each bench mark is equally weighted toward the goal of completing 100% of benchmarks.

Year one activities = Target: 33 % (5 of 15 benchmarks)

If all 5 elements below are completed, the score will be 33%. If all items are not completed, the score will be reduced proportionately. Each element completed is worth 6.6%.

1. Identifed state and local health and allied groups' previous and current efforts to assess food security and hunger among Washington MCH population.
2. Identified and analyzed existing data for measuring Food Security indicators for the MCH population.
3. Identified present MCH activities and developed partnerships locally and at the state level that promote food security among the MCH population.
4. Raised awareness by including Food Security issues, resources, and findings regarding Washington state population through trainings targeting Public Health and Maternity Support Services Staff.
5. Searched for and identified opportunities for funding initiatives focusing on Food Security issues.

Year two activities = Target: 66% (10 of 15 Benchmarks)

If all 5 elements below are completed, the score will be 66%. If all items are not completed, the score will be reduced proportionately. Each element completed is worth 6.6%.

6. Maintained partnerships and disseminated baseline data to local health departments and other partners
7. Convened a work group of local and state constituents related to MCH health promotion and who can represent Food Security and/or hunger issues.
8. Learned best practices for MCH population from other state's public health interventions and literature review regarding promoting Food Security.
9. The workgroup will have identified and prioritized measurable indicators of Food Security to incorporate into an action plan.
10. Researched and shared funding opportunities for state or locals, such as Food Stamp Education Project.

Year three activities = Target: 80% (12 of 15 benchmarks)
If both elements below are completed, the score will be 80%. If all items are not completed, the score will be reduced proportionately. Each element completed is worth 7%.
11. Completed Strategic Plan to promote and protect Food Security for MCH population. Plan will specify indicators, interventions, data collection, outcomes, and evaluation.
12. Sought and obtained resource commitments for interventions and evaluation.

Year four activities = Target: 100% (15 of 15 benchmarks)
If all 3 elements below are completed, the score will be 100%. If all items are not completed, the score will be reduced proportionately. Each element completed is worth 6.6%.
13. Maintained partnerships and mutual commitments.
14. As resources are allowed, implemented, interventions according to Plan.
15. Collected data and evaluated indicators/outcomes and interventions.

Year five, completed benchmarks if not completed by year four.
Updated Plan and continued implementation.

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